PSYCHIATRIC INPATIENT FACILITY UTILIZATION AND PLACEMENT REVIEW MANUAL

Cabinet for Human Resources
Department for Medicaid Services

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KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

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PART I

REVIEW PROCEDURES

1.0 Executive Summary:

The Kentucky Department for Medicaid Services has contracted with a review agency to develop and implement a utilization review program for psychiatric inpatient admissions. The review agency shall on Medicaid's behalf determine the medical necessity for psychiatric inpatient care and shall verify the facility's compliance with applicable Medicaid regulations. The review agency shall also conduct an annual Inspection of Care evaluation of all Medicaid1 recipients, applicants and potential applicants residing in psychiatric facilities to determine whether the services providled in the facility are adequate and necessary to meet the health needls of each recipient.

The Kentucky Department for Medicaid Services has established this objective, third party clinical evaluation system for three important reasons: (1) to make more efficient use of finite health care benefits; (2) to ensure, that Medicaid recipients are receiving care in the least restrictive, most clinically appropriate environments; and (3) to identify the gaps in the State's continuum of mental health care and to improve care by developing recommendations for new community programs or reimbursement policies.

The Psychiatric Inpatient Facility Utilization and Placement Review Manual is incorporated by reference in 907 KAR 1:016 Psychiatric Hospital Services and cross-referenced in 907 KAR 1:505 Psychiatric Residential Treatment Facility Services.

2.0 Definition of Terms:

The Department for Medicaid Services and the review agency have agreed to certain definitions for services and patient status that shall serve to provide a common reference point for consistent implementation of the program. These definitions are as follows:

a. Psychiatric Emergency - Sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ or part or death of the individual or harm to another person by the individual.

b. Elective Admission - Any admission for a condition which is non-emergency but which cannot be treated in an ambulatory setting.

c. Emergency Admission - Any admission for an emergency condition which requires the prompt provision of inpatient care.

d. Pre-Admission Certification Review - A review process which assures that ambulatory care resources available in the community do not meet the needs of the recipient; that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services are no longer needed.

e. Recertification Review - A review which is requested by the facility to determine if there is a need for an additional stay in the psychiatric facility. The criteria used for recertification reviews shall be essentially the same as those used for pre-admission reviews.

f. 30-Day Review - An individual in-facility case review performed after the thirtieth (30th) day of the admission to determine if the admission is in compliance with applicable Medicaid regulations relating to pre-admission, admission and utilization control.

g. Telephone Review - A pre-admission certification or recertification review in which a recipient's case is reviewed over the telephone.

h. Face to Face Review - A pre-admission review or recertification review in which a recipient or his treating clinicians are seen personally by a clinical professional designated by the review agency at a location convenient to the recipient. A patient shall not be required to leave the facility for a recertification review. Reviews shall first be conducted by telephone. A face to face review shall be requested only when the telephone review provides insufficient clinical information upon which to make a decision.

i. Working Day - Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Time, excluding State Holidays.

j. Patient - An individual age 21 and under or 65 and over who has a Medicaid card or for which an application to Medicaid has been made or will be made.

k. Guardian - The patient's parent, patient's legal guardian, or custodian.

1. IOC - A professional annual evaluation of each Medicaid recipient, applicant or potential applicant in a given inpatient psychiatric facility to determine whether the services available in the facility are adequate and appropriate to meet the patients' health needs.

m. Conversion - The circumstance under which an individual becomes eligible for Medicaid after admission to a psychiatric facility.

3.0 Pre-Admission Certification Review for Elective Admissions:

3.1 An elective pre-admission review shall be telephoned using a toll-free line to the review agency prior to admission. The patient shall have a Medicaid card and a valid Certification of Need (CON) which satisfies the conditions of 42 CFR 441.152 and 42 CFR 441.153 for patients age twenty-one (21) and under or 42 CFR 456.160 for patients aged sixty-five (65) and older must have been completed.

3.2 The physician or facility shall be responsible for initiating the pre-admission review. A psychiatric utilization reviewer shall be responsible for taking all telephone reviews. Telephonic reviews shall be completed within one (1) working day after notification by the facility; however, most telephonic reviews should be completed during the initial contact. Failure to provide or record data required to establish the need for inpatient psychiatric services shall result in a denial1 of the admission. The review agency psychiatric reviewers are supervised by a psychiatrist and all denials shall be made by a psychiatrist.

3.3 The following minimum information is required to complete a pre-admission certification review:

a. A DSM-III-R Diagnosis on all five (5) axes, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for inpatient psychiatric treatment;

b. A description of the initial treatment plan relating to the admitting symptoms;

c. Current symptoms requiring inpatient treatment;;

d. Medication history;

e. Prior hospitalization;

f. Prior alternative treatment;

g. Appropriate medical, social and family histories; and

h. Proposed aftercare placement.

If the patient clearly meets Medicaid's criteria for medical necessity (as described in Parts II, III or IV of this manual), a certification shall be made for a length of stay specified by the reviewer. If a determination is not possible at this point, the reviewer shall schedule a face to face review at a location convenient to the recipient. Failure to provide or record data required to establish the need for inpatient psychiatric services shall result in a denial of the admission. When the certification is made for a length of stay, a certification number shall be given to the facility.

Reviewers shall also verbally verify the following:

a. Certification of Need (MAP-569) Form has been signed by an independent team; or

b. Requirements for physician certification of need for inpatient care as specified by 42 CFR 456.160(a)(1)(2) have been met for patients age sixty-five (65) and over;

c. Medical, social and psychiatric evaluations have been performed and placed in the patient's record; and

d. A plan of care has been established and placed in the patient's record.

3.4 Upon conclusion of the pre-admission certification, the review agency shall make one (1) of the following determinations:

a. Treatment in an inpatient psychiatric facility is medically necessary. Form LO2 will be sent and shall contain a description of the recipient's rights to a reconsideration.

b. As determined by a psychiatrist, the patient's condition does not require inpatient services under the direction of a physician. Form LO5 will be sent and shall contain a description of the recipient's rights to a reconsideration.

3.5 Upon completion of the review, Medicaid shall notify through the review agency all relevant parties in the following manner:

a. The facility or physician shall be immediately notified of the determination by telephone and shall be provided with the certification number if appropriate.

b. The patient or guardian, recipient, physician, DSI and facility shall be notified of the determination by first-class mail. The notice shall be mailed by the review agency within two (2) working days after the pre-admission certification review is completed.

3.6 Inpatient facilities shall bear the responsibility for notifying the patient that Medicaid eligibility does not imply the need for psychiatric inpatient facility services and vice versa.

3.7 If the patient fails to keep an appointment for a face to face review, it may be rescheduled.

3.8 Certifications for pre-admission reviews shall remain in effect for the days certified by the review agency and failure to admit the recipient within that time frame shall necessitate a new review. In no case may the certification be for longer than thirty (30) days.

3.9 The availability and accessibility of appropriate, less restrictive treatment alternatives shall constitute a basis for denying inpatient care.

4.0 Review for Emergency Admissions:

4.1 Retrospective admission reviews on behalf of the Medicaid Department shall be performed for all emergency admissions. Documentation in the recipient's medical records must justify the emergency designation. A facility is "at risk" for Medicaid reimbursement until certification is obtained from the review agency. The reviews shall assure that ambulatory care resources available in the community do not meet the needs of the recipient; that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services are no longer needed. These reviews also verify the facility's compliance with applicable Medicaid regulations relating to pre-admission, admission and utilization control.

4.2 Reviews shall be conducted principally by telephone using a toll-free line. Reviewers may request the transmittal of appropriate medical records or additional written documentation which is necessary to complete the review. Face to face interviews may be scheduled with the recipient or his attending

clinicians when the medical necessity of the admission cannot be determined by telephone review. Failure to provide or record data required to establish the need for inpatient psychiatric services shall result in a denial of the admission. Determinations and notifications shall be made in the same manner as for elective pre-admission reviews.

4.3 Reviewers shall as a minimum perform the following functions:

a. Verify that the requirements of 42 CFR 441.152(a)(b), 441.153(a)(c), 441.154(a)(b) and 441.155(a)(b) as they relate to the certification of emergency admissions have been met. (Form MAP-570 shall be completed.)

b. Verify that the requirements for physician certification of need for inpatient care as specified by 42 CFR 456.160 (a)(1)(2) have been met for patients age sixty-five (65) and over..

c. Verify that the medical, social and psychiatric evaluations of the recipient as required by 42 CFR 456.170(a)(b) have been performed and have been placed in the recipient's medical record as required by 42 CFR 456.181(a)(b).

d. Verify that a plan of care has been established for the recipient in accordance with 42 CFR 456.180(a)(b) and has been placed in the recipient's records as required by 42 CFR 456.181(a)(b).

e. Use in their determination the Medicaid Review Criteria for medical necessity (Placement Review Guidelines) as described in Parts II, III or IV of this manual.

4.4 Telephonic reviews shall be completed within one (1) working day after notification of the admission by the facility; however, most telephonic reviews should be completed during the initial contact. When a visual review of the patient's records is required, the reviews should be completed within one (1) working day of the receipt of the records. When a face to face review is required, it shall be conducted within five (5) working days of the initial request from the facility. Face to face reviews shall be conducted at the facility.

4.5 It is the responsibility of the facility to notify the review agency of all emergency admissions as soon as possible after the admission. To insure timely review, the facility's notification shall never be later than two (2) working days after the admission. When the facility notification is late, the review agency shall deny certification for the interval between admission and the date the certification is requested by the facility.

5.0 Conversion to Medicaid Status After Admission:

5.1 Retrospective admission reviews on behalf of the Medicaid Department shall be performed for all patients who convert to Medicaid eligibility after their admission to the facility. The review shall assure that ambulatory care resources available in the community do not meet the needs of the recipient; that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services are no longer needed. These reviews also verify facility compliance with applicable Medicaid regulations relating to pre-admission, admission and utilization control.

Determinations and notifications shall be made in the same manner as for elective pre-admission reviews.

The facility shall notify the review agency of the date the recipient makes or plans to make application for Medicaid and the anticipated or requested date of eligibility.

5.2 Reviews shall be conducted principally by telephone using a toll-free line. Reviewers may request the transmittal of appropriate medical records or any additional written documentation which is necessary to complete the review. Face to face interviews may be scheduled with the recipient or his attending clinicians when the medical necessity of the admission cannot be determined by telphone review.

5.3 Reviewers shall at a minimum perform the following functions:

a. Verify that the requirements of 42 CFR 441.152(a)(b), 441.153(a)(b), 441.154(a)(b) and 441.155(a)(b) as they relate to individuals who apply for Medicaid after admission are met. (Form MAP-570 shall have been completed.)

b. Verify that the requirements for physician certification of need for inpatient care as specified by 42 CFR 456.160 (a)(1)(2) have been met for patients age 65 and over.

c. Verify that the medical, social and psychiatric evalations of the recipient as required by 42 CFR 456.170(a)(b) have been performed and have been placed in the recipient's medical record as required by 42 CFR 456.181(a).

d. Verify that a plan of care has been established for the recipient in accordance with 42 CFR 456.180(a)(b) and has been placed in the recipient's records as required by 42 CFR 456.181(a).

e. Use in their determination the Medicaid Review Criteria for medical necessity Placement Review Guidelines as described in Parts II, III or IV of this manual.

5.4 Telephonic reviews shall be completed within one (1) working day after notification of the admission by the facility; however, most telephonic reviews should be completed during the initial contact. When a visual review of the patient's records is required, the review should be completed within one (1) working day of the receipt of the records. When a face to face or on-site review is required, it shall be conducted within five (5) working days of the initial request from the facility, Face to face reviews shall be conducted at the facility. Failure to provide or record data required to establish the need for inpatient psychiatric services shall result in a denial of the admission.

5.5 Reviews shall be completed before Medicaid payment may be authorized and shall consider all days before application for which claims are made.

6.0 Recertification Review:

6.1 It shall be the facility's responsibility to call the review agency prior to the certification expiration date when additional days of stay are felt to be necessary by the attending physician.

6.2 All recertification reviews shall be conducted initially by telephone by the reviewer with the facility designee or the attending physician.

6.3 The following information from the physician or inpatient facility is required to complete a recertification review:

a. Current DSM-III-R diagnosis on all five (5) axis, except that failure to record an axis IV or V diagnosis shall be used as the basis for a denial only if those diagnoses are critical to establish the need for inpatient psychiatric treatment;

b. Assessment of treatment program with regard to admitting symptoms;

c. Summary of treatment provided to the point of review and assessment of need for further treatment;

d. Medication record with specific emphasis on frequency, dosage and side effects;

e. Family involvement in the treatment process;

f. Validation of functioning levels;

g. Discharge plans (presence of well written plan and implementation thereof);

h. Psychological testing results (if applicable);

i. Physician's documentation of the need for inpatient services;

j. Medical, social and psychiatric evaluations formulated and placed in the patient's record; and

k. A plan of care has been established and placed in the patient's records.

6.4 Upon the completion of recertification reviews, the review agency shall be responsible for denying or certifying an additional length of stay in accordance with the placement criteria listed in Parts II, III or IV of this manual and for completing and distributing appropriate notices and forms in accordance with Medicaid guidelines. The review agency's length of stay determinations shall be used as the basis for Medicaid payments for inpatient care.

6.5 The availability and accessibility of appropriate, less restrictive treatment alternatives shall constitute a basis for denying inpatient care.

6.6 The review agency's psychiatrist shall deny the patient's stay, if the facility, as a result of the reviewer's visual inspection of records, is found to be in non-compliance with applicable Medicaid regulations relating to admission certification or utilization review. Such denials shall be retroactive to the date of non-compliance, and Medicaid shall request appropriate refunds.

6.7 Medicaid payments shall end on the last inpatient day certified by the review agency.

6.8 If the patient's admission clearly meets Medicaid's technical and medical criteria, a certification shall be made for a length of stay specified by the reviewer. If a determination is not possible at this point, a face to face review shall be scheduled at the facility in which the individual is a patient.

6.9 Upon completion of a recertification review, the review agency shall make one of the following determinations:

a. Treatment in an inpatient psychiatric facility is medically necessary. Form LO2 shall be issued and shall contain a description of the recipient's rights to a reconsideration.

b. As determined by a psychiatrist, the patient's psychiatric condition does not require inpatient services under the direction of a physician or the admission is not otherwise in compliance with Medicaid requirements. Medicaid payment shall end on the last inpatient day certified by the review agency. Form LO5 shall be sent and shall contain a description of the recipient's rights to a reconsideration.

6.10 Upon completion of a recertification review, Medicaid shall notify through the review agency all relevant parties of the determination as follows:

a. The attending physician or inpatient facility shall be immediately notified of the determination by telephone.

b. When days of stay are certified, the patient or guardian shall be notified of the determination in writing by first-class mail. The notice shall be mailed by the review agency within two (2) working days after the review is completed and shall include a description of the patient's rights to a reconsideration.

c. In all cases in which the patient's condition is deemed not to require inpatient care, the patient or guardian, D.S.I., the facility, Medicaid and the physician shall be notified of the adverse determination by first-class mail within two (2) working days after the review is completed. The patient or guardian shall be notified of the appeals process described in Section 11.0.

7.0 30-Day Reviews:

7.1 The review agency shall perform an on-site review after the thirtieth (30th) day of the patient's admission. However, this requirement may be waived in writing by DMS on a patient-specific or collective-patient basis.

7.2 This thirty (30) day on-site review verifies compliance with applicable Medicaid regulations relating to pre-admission, admission and utilization control.

7.3 The on-site reviews may be performed by a psychiatric social worker (MSW) or a board-certified psychiatrist or a Ph.D. psychologist or a masters-level psychologist with autonomous functioning or a psychiatric nurse with five (5) years experience.

7.4 The procedures for notification of Medicaid and relevant parties are the same as those for recertification reviews.

7.5 The facility's and physician's responsibilities are the same as those previously described for recertification reviews, except that these 30-day reviews shall be initiated by the review agency.

7.6 In all cases in which the patient's condition as determined by a psychiatrist is deemed not to require inpatient care, or the admission is otherwise found by the reviewer not to be in compliance with Medicaid requirements, the review agency shall issue an Adverse Determination Form, L05, and the patient or guardian shall be notified of the appeals process described in Section 11.0.

8.0 **Inspection of Care (IOC) Reviews:**

8.1 The IOC team shall determine in its inspection whether:

a. The services available in the facility are adequate to meet the health needs of each recipient and promote his maximum physical, mental and psychosocial functioning;

b. It is necessary and desirable for the recipient to remain in the facility;

c. It is feasible to meet the recipient's health needs through alternative institutional or noninstitutional service;

d. Each recipient is receiving active treatment as defined in 42 C.F.R. 441.154(a)(b); which states:

1. Inpatient psychiatric services shall involve active treatment, which means implementation of a professionally developed and supervised individual Plan of Care.

2. The Plan of Care is developed and implemented no later than fourteen (14) days after admission; and

3. Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

e. The admission is in compliance with applicable Medicaid regulations relating to pre-admission, admission and utilization control.

8.2 The basis for IOC Team determination shall be whether or not:

a. The medical, social and psychiatric evaluations, and the plans of care are complete and current; the plans of care are followed; and all ordered services are provided and recorded;

b. The attending physician reviews prescribed medications at least every thirty (30) days;

c. Tests or observations of each recipient indicated by this medication regimen are made at appropriate times and properly recorded;

d. Physician, nurse and other professional progress notes are made and are consistent with the observed condition of the recipient;

e. The recipient receives adequate services, based on observations (cleanliness; absence of signs of malnutrition or dehydration; and maintenance of maximum physical, mental and psychosocial function);

f. The recipient needs any service that is not furnished by the facility or through arrangements with others; and

g. The recipient needs continued placement in the facility or there is an appropriate plan to transfer the recipient to an alternate method of care.

8.3 Within ten (10) working days of the IOC, the team shall submit a report documenting the observations, conclusions and recommendations of the team concerning:

a. The adequacy, appropriateness and quality of all services provided in the facility, including physician services to recipients;

b. Specific findings pertaining to individual recipients in the facility; and

c. Facility compliance with 42 CFR 456.241(a)(b), 452.242(a)(b), 456.243(a)(b)(c), 456.244(a)(b)(c) and 456.245 which requires that ongoing medical care evaluation studies be performed.

8.4 The report shall include the dates of the IOC along with the names, titles and signatures of the team members and a copy shall be forwarded to:

a. The facilty inspected;

b. The Division of Licensing and Regulation;.

c. The Department for Mental Health Services; and

d. The Department for Medicaid Services, Division of Patient Access and Assessment.

8.5 The report shal 1 call for the facility to submit a corrective action plan no later than thirty (30) days from the date of the IOC report.

8.6 Follow-up visits shall be conducted when appropriate, within ninety (90) days of the IOC to assess compliance with corrective action plans. A follow-up report shall be forwarded to the Department for Medicaid Services, Division of Patient Access and Assessment within ten (10) working days of the follow-up visit.

8.7 No facility may be notified of the time of the IOC or follow-up visit more than forty-eight (48) hours prior to the scheduled arrival of the team.

9.0 Time Frame Periodicity:

9.1 An annual on-site review is required in a facility by the end of a quarter that the facility entered the Medicaid Program during the same calendar quarter one (1) year earlier; or the facility has not been reviewed since the same calendar quarter one (1) year earlier.

9.2 An annual on-site review is required of each Medicaid recipient, applicant or potential applicant in every facility, regardless of location, by the end of the quarter in which the review is required.

9.3 An annual on-site review is required if the State Agency intends to claim FFP even if the recipients receive care in a facility whose provider agreement has expired or been terminated.

10.0 **Confidentiality:**

10.1 The review agency (including its subcontractors) is required by State Law to maintain the confidentiality of all patient records. As an agent of Medicaid, the review agency is entitled to all provider medical records to which Medicaid is entitled under its agreement to reimburse providers for services. The records shall only be shared with Medicaid in connection with the appeals process or with other parties approved in writing by the patient or guardian. All records and clinical information shall be treated confidentially by all individuals involved in the review process.

11.0 **Appeals:**

11.1 The review agency shall provide the Medicaid recipient, applicant, or his authorized representative with the opportunity for a timely reconsideration. The review agency shall notify in writing. the recipient, the physician of record, the facility, the Medicaid Department and the Department for Social Insurance of the review agency's determination within two (2) working days of the decision. The written notice of a certification (Form L02) or of an adverse determination (Form L05) shall include the following information:

a. A statement of the agency's intended action;

b. The reason for the intended action;

C. The specific regulations that support the action;

d. A description of the recipient's rights to reconsideration.

11.2 The review agency may certify an admission based on the receipt of additional information, prior to conducting a reconsideration. Form L02 shall be used for this purpose.

11.3 The review agency shall conduct the reconsideration and its decision shall be based solely upon available medical and technical information and such additional evidence as may have been submitted for review by the facility, the physician of record, the patient or the patient's representative. The review agency shall accept a written request for a reconsideration

when the request is made within thirty (30) days from the date of the review agency's determination notice. To be considered, copies of medical records or evidence or other pertinent information shall be submitted with the reconsideration request. When requested in advance by the patient or his representative, the reconsideration shall be performed by a board eligible or certified physician in the appropriate psychiatric specialty or subspecialty. The review agency shall conduct the reconsideration within three (3) working days from the date of receipt of the written request. Failure to conduct the reconsideration within this time frame shall not, however, serve as a basis for certifying days of stay.

11.4 The review agency shall notify the recipient, the facility, the attending physician, DSI and the Medicaid Department in writing within two (2) working days of their determination of the result of the reconsideration. Form L07 shall be sent for this purpose.

11.5 The review agency shall advise the recipient of further appeal rights and the procedures for exercising this right. Such subsequent appeals shall be made to the Medicaid Program and shall be presented at a formal hearing conducted by the Medicaid Program.

11.6 The review agency shall provide a physician representative to present the review agency's decision at subsequent Medicaid Department administrative hearings. The Medicaid Department may, however, in writing, and on a case by case basis, waive this requirement to permit other categories of mental health professionals to represent the review agency at administrative hearings. The review agency shall provide to the Medicaid Department all relevant documentation in cases where requests for an administrative hearing at the Medicaid Department level are made.

12.0 Staffing:

12.1 The following categories of professionals shall conduct Pre-Admission Certification, Admissions Certification, Recertification and 30-day Reviews:

Board-Certified Psychiatrist; or
Ph.D. Psychologist; or
M.A. Psychologist with Autonomous Functioning; or
Licensed Psychiatric Social Worker; or
Psychiatric Nurse with five (5) years experience.

12.2 The Inspection of Care Team consists of:

Board-Certified Psychiatrist; and
Ph.D Psychologist; or
M.A. Psychologist with autonomous functioning; or
Licensed Registered Nurse with specialized training in treating mentally ill individuals; or
a Licensed Psychiatric Social Worker.

12.3 A member of the Inspection of Care Team that reviews care in an inpatient psychiatric facility shall not:

a. Have a financial interest in any institution of that same type;

b. Review care in an institution where he or she is employed; or

c. Inspect the care of the recipient for whom he or she is the attending physician.

13.0 Data Collection and Reporting:

13.1 Information obtained in each telephone review shall be entered directly into the review agency's data base, and it shall be the responsibility of the reviewer of record to complete the required data elements before a review is completed and a determination made. Compliance shall be audited periodically by the review agency director of management information systems.

13.2 When a face to face review is conducted, the reviewer shall use a hard copy review form, the contents of which shall be entered into the data base.

13.3 Reports shall be developed in a format acceptable to Medicaid. These reports shall at a minimum include patient demographics; review outcomes by facility, region and diagnosis; frequency of specific diagnoses; and analysis and recommendations by region concerning the availability, or lack of, alternative treatment resources to hospitalization.

14.0 Quality Assurance:

14.1 Credentialing - The review agency shall obtain and keep on file all relevant licenses and certification of its reviewers and practitioners. It shall also exercise due diligence in investigating the backgrounds and professional standing of practitioners employed or under contract.

14.2 Liability Coverage - The review agency and its subcontractor shall maintain adequate professional liability insurance coverage. Documentation to this effect shall be kept on file by the review agency.

14.3 The review agency shall randomly audit completed reviews to assess whether they have been conducted in full accordance with its established procedures and criteria.

14.4 The review agency shall ensure that the appropriate clinical representative visits each Medicaid inpatient facility at least once per quarter to give hospitals an opportunity to make recommendations for the ongoing refinement of the program.

PART II

PLACEMENT REVIEW GUIDELINES

CRITERIA FOR ADMISSION TO AND CONTINUED STAY IN KENTUCKY MEDICAID UNDER 21 PSYCHIATRIC HOSPITAL

PLACEMENT REVIEW GUIDELINES
Criteria for Admission to and
Continued Stay in
A Kentucky Medicaid Under 21
Psychiatric Hospital

The following are criteria to be used for admission to and continued stay in a psychiatric hospital when reimbursement is to be made on behalf of eligible recipients of Title XIX benefits.

I. Criteria For Psychiatric Hospital Services To Individuals Under Age 21.

REQUIREMENTS A, B, AND C SHALL BE MET FOR ADMISSION TO A PSYCHIATRIC HOSPITAL.

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipients (42 CFR 441.152(a)),

To meet this requirement, one (1) of the following shall be established.

1. A lower level of care will not meet the individual's treatment needs. Examples of lower levels of care include:

   a. Family or relative placement with outpatient therapy
   b. Day or after-school treatment
   c. Foster care with outpatient therapy
   d. Therapeutic foster care
   e. Group child care supported by outpatient therapy
   f. Therapeutic group child care
   g. Partial hospitalization
   h. Other; or

2. An appropriate lower level of care is unavailable or inaccessible; or

3. The individual's mental disorder could be treated with a lower level of care; but because the individual suffers one or more complicating concurrent disorders, inpatient care is medically necessary at a higher level of care.

   Examples:

   a. Conduct disorder with epilepsy
   b. Depression with insulin-dependent diabetes
   c. Depression with renal dialysis; or

4. Factors related to the individual's family or community indicate against treatment at a lower level of care; for example:

a. Patient does not have adequate support (family, school or community) to use a lower level of care and the individual is not appropriate for an alternative living arrangement (e.g., foster care).
b. Family persistently hampers treatment, making treatment in a lower level of care ineffective.
c. Patient behavior persists despite appropriate treatment in a lower level of care and either seriously disrupts family life or arouses antagonism toward the patient, placing the individual at risk or making treatment in a lower level of care ineffective.
d. Other

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, determine all of the following requirements:

1. The patient has a psychiatric condition or disorder which is classified as a DSM III-R (Diagnostic and Statistical Manual, Third edition revised, 1987) Axis I diagnosis (other than a primary diagnosis of chemical dependency or abuse). Individuals with an Axis II diagnosis may be considered if an Axis I diagnosis indicates a need for treatment; and

2. The individual's rating on DSM III-R Axis IV is four (4) or greater. The rating on DSM III-R Axis V at admission to a psychiatric hospital is fifty (50) or less. However, the Axis IV or V diagnosis rating shall be used as the basis for a denial only if those diagnoses are critical to establish the need for inpatient psychiatric hospital treatment; and

3. The individual is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one (1) of the following categories designated as (a), (b), (c) and (d):

a. Self-care Deficit (not Age Related): Basic impairment of needs for nutrition, sleep, hygiene, rest, or stimulation related to the individual's mental disorder.

Indicators:
(1) Self-care deficit severe and long-standing enough to prohibit participation in an alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications).

(2) Self-care deficit places child in life-threatening physiological imbalance without skilled intervention and supervision (examples: dehydration, starvation states, exhaustion due to extreme hyperactivity).
(3) Sleep deprivation or'significant weight loss; or

b. Impaired Safety (Threat to Self or Others): Verbalization or gestures of intent to harm self or others caused by the individual's mental disorder.

Indicators:
(1) Threats accompanied by one of the following:
(a) Depressed mood (irritable mood in children, weight gain, weight loss)
(b) Recent loss
(c) Recent suicide attempt or gesture or past history of multiple attempts or gestures
(d) Concomitant substance abuse
(e) Recent suicide or history of multiple suicides in family or peer group
(f) Aggression toward others
(2) Verbalization escalating in intensity; or verbalization of intent accompanied by gesture or plan; or

c. Impaired Thought Processes (Reality Testing): Inability to perceive and validate reality to the extent that the child cannot negotiate his basic environment, nor participate in family or school (paranoia, hallucinations, delusions).

Indicators:
(1) Disruption of safety of self, family, peer or community group.
(2) Impaired reality testing sufficient to prohibit participation in any community educational alternative.
(3) Not responsive to outpatient trial of medication or supportive care.
(4) Requires inpatient diagnostic evaluation to determine treatment needs; or

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes which place the individual at risk.

Indicators:
(1) Family environment is causing escalation of individual's symptoms or places individual at risk.
(2) The family situation is not responsive to outpatient or community resources and intervention.
(3) Instability or disruption is escalating.
(4) The situation does not improve with the provision of economic or social resources.
(5) Severe behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse; and

4. The Qualified Mental Health Professional describes a proposed plan of treatment that requires the intensity of services available at an inpatient psychiatric level of care; specifically:

a. Services shall be under the supervision of-a psychiatrist.
b. Intervention of qualified professionals shall be available twenty-four (24) hours a day.
c. Multiple therapies (group counselling, individual counselling, recreational therapy, expressive therapies, etc.) shall be actively provided to the child.

C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1. The treatment facility shall provide a description of the plan for treatment illustrating the required intensity of services available at an inpatient psychiatric level of care.

2. The treatment facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, and time-framed discharge criteria.

3. Available clinical and research data supports the likelihood of positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.

D. When determining whether a placement shall be made in a hospital, a PRTF shall be considered a less restrictive potential alternative.

II. **Specific Services Which Do Not Meet The Criteria For Inpatient Psychiatric Facility Care.**

Care needs considered as not meeting the criteria for psychiatric facility care include but shall not be limited to:

A. **Medically unnecessary admissions.**

B. **Services to recipients between the ages of 21 and 65; except that a recipient who is hospitalized and is receiving covered psychiatric services prior to his 21st birthday may be covered during a continuous period of hospitalization up to the age of 22, if the services are determined to be medically necessary.**

c. **Substance abuse services when these services are the primary or exclusive service provided.**

D. **Persons with major medical problems and minor symptoms, or for whom psychiatric consultation might be utilized rather than psychiatric facility admission.**

E. **Patients who need only adequate living accommodations, economic aid or social support services.**

PART III

PLACEMENT REVIEW GUIDELINES

INPATIENT PSYCHIATRIC CARE FOR PERSONS AGE 65 AND OVER

Inpatient Psychiatric Care for Persons Age 65 and Over

The following are criteria to be used for admission to and continued stay in a mental hospital when reimbursement is to be made on behalf of eligible recipients of Title XIX benefits.

I. Criteria for Mental Care for Persons Age 65 and Over

The patient shall meet requirements of A., B., and C. to be qualified for mental hospital care:

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipients.

1. A lower level of care will not meet the recipient's treatment needs; or

2. An appropriate lower level of care is unavailable or inaccessible; or

3. The recipient's mental disorder could be treated with a lower level of care; but because the individual suffers one (1) or more complicating concurrent disorders, inpatient care is medically necessary at a higher level of care.

Examples:

a. Conduct disorder with epilepsy
b. Depression with unstable insulin-dependent diabetes
c. Depression with renal dialysis.

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

1. A Qualified Mental Health Professional has made a DSM-IIIR Axis I diagnosis of a mental disorder other than a primary diagnosis of chemical dependency. Individuals with an Axis II diagnosis may be considered if an Axis I diagnosis indicates a need for treatment; and

2. One of the following problem areas related to the mental disorder diagnosed in B. 1. above is identified and substantiated by the Qualified Mental Health Professional:

a. Impaired Safety (Threat to Self or Others): Verbalization or gestures of intent to harm self or others caused by the individual's mental disorder.

Indicators:

(1) Threats accompanied by one (1) of the following:
(a) Depressed mood
(b) Recent loss
(c) Recent suicide attempt or gesture or past history of multiple attempts or gestures
(d) Concomitant substance abuse
(e) Aggression toward others.
(2) Verbalization escalating in intensity; or verbalization of intent accompanied by gesture or plan; or

b. Impaired Thought Processes (Reality Testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his basic environment (paranoia, hallucinations, delusions); or

c. Self-Care Deficit: Basic impairment of needs for nutrition, sleep, hygiene, rest, stimulation related to the individual's mental disorder, or appropriate attention to a concurrent physical disorder or disease; and

3. The Qualified Mental Health Professional describes a proposed plan of treatment that requires the intensity of services available at an inpatient psychiatric level of care specifically:

a. Services shall be under the supervision of a psychiatrist.

b. Intervention of qualified professionals shall be available 24 hours a day.

c. Multiple therapies (group counselling, individual counselling, recreational therapy, expressive therapies, etc.) shall be actively provided to the patient.

C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed, or, for chronically mentally ill adults as described in KRS 210.005(3), who are admitted to the hospital under a KRS Chapter 202A commitment, maintain the individual at, or restore him to, the greatest possible degree of health and independent functioning. The KRS Chapter 202A commitment requirement shall not apply to any individual age 65 or over who was a resident of the same hospital as that in which he is currently residing on December 28, 1994. To meet this requirement at admission, a Qualified Mental Health Professional shall propose an aftercare placement and state that inpatient psychiatric care is necessary before the proposed aftercare placement will be appropriate for the recipient.

The treatment team shall have developed a comprehensive discharge plan with discrete, behavioral, and time-framed discharge criteria, as appropriate.

II. Examples of Mental Hospital Care

Examples of mental hospital care may include, but are not limited to the following:

A. Administration of psychotropic medications or treatments which cannot be managed on an outpatient basis.

B. Severe organic brain disease with behavior unresponsive to medication and too disturbing to be managed at home or in another facility, such as the physically aggressive patient or person dangerous to self or others.

C. Patients who during episodes of agitation or restlessness produced by a stress situation may require brief mental hospital treatment.

D. Those who require periods of protection from the consequences of their behavior during episodes of acute disturbance or depression (suicide, homicide, refusal to eat, etc.).

E. Management of patients with impaired ability to manage their own Activities of Daily Living (ADL's) due to a failure of social functioning.

III. Specific Services Which Do Not Meet The Criteria For Mental Hospital Care

Care needs considered as not meeting the criteria for mental hospital care include but shall not be limited to:

A. Medically unnecessary admissions.

B. Services to recipients between the ages of 21 and 65; except that a recipient who is hospitalized and is receiving covered

C. Substance abuse services when these services are the primary or exclusive service provided.

D. Persons with major medical problems and minor symptoms, or for whom psychiatric consultation might be utilized rather than mental hospital admission.

E. Persons with inconsequential lapses of memory and mild disorientation as a result of chronic brain syndrome, who are more effectively treated or managed in their own homes, nursing home, etc., and for whom a mental hospital has little to offer and may even aggravate their confusion.

F. Patients who need only adequate living accomodations, economic aid or social support services.

PART IV

PLACEMENT REVIEW GUIDELINES

CRITERIA FOR ADMISSION TO AND CONTINUED STAY IN KENTUCKY MEDICAID UNDER 21 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

PLACEMENT REVIEW GUIDELINES
Criteria for Admission to and
Continued Stay in
Kentucky Medicaid Under 21
Psychiatric Residential Treatment Facilities (PRTF)

The following are criteria to be used for admission to and continued stay in psychiatric residential treatment facilities when reimbursement is to be made on behalf of eligible recipients of Title XIX benefits. Not all children appropriate for inpatient psychiatric care will be appropriate for PRTF care; generally, PRTF care will be appropriate only for children whose problems are severe, complex, and persistent.

REQUIREMENTS A, B, C AND D SHALL BE MET FOR ADMISSION TO AND CONTINUED STAY IN A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY.

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipients (42 CFR 441.152(a)).

To meet this requirement, one (1) of the following shall be established.

1. A lower level of care will not meet the individual's treatment needs. Examples of lower levels of care include:

   a. Family or relative placement with outpatient therapy
   b. Day or after-school treatment
   c. Foster care with outpatient therapy
   d. Therapeutic foster care
   e. Group child care supported by outpatient therapy
   f. Therapeutic group child care
   g. Partial hospitalization
   h. Other; or

2. An appropriate lower level of care is unavailable or inaccessible; or

3. The individual's mental disorder could be treated with a lower level of care; but because the individual suffers one (1) or more complicating concurrent disorders, inpatient care is medically necessary at a higher level of care.

   Examples:

   a. **Conduct disorder with epilepsy**
   b. Depression with insulin-dependent diabetes
   c. Depression with renal dialysis; or

4. Factors related to the individual's family or community indicate against treatment at a lower level of care; for example:

   a. Patient does not have adequate support (family, school or community) to use a lower level of care and the individual is not appropriate for an alternative living arrangement (e.g., foster care).
   b. Family persistently hampers treatment, making treatment in a lower level of care ineffective.
   c. Patient behavior persists despite appropriate treatment in a lower level of care and either seriously disrupts family life or arouses antagonism toward the patient, placing the individual at risk or making treatment in a lower level of care ineffective.
   d. Other.

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, determine all of the following requirements:

1. The patient has a psychiatric condition or disorder which is classified as a DSM III-R (Diagnostic and Statistical Manual, Third edition revised, 1987) Axis I diagnosis (other than a primary diagnosis of chemical dependency or abuse). Individuals with an Axis II diagnosis may be considered if an Axis I diagnosis indicates need for treatment; and

2. The individual's rating on DSM III-R Axis IV is four (4) or greater. The rating on DSM III-R Axis V at admission to a psychiatric facility is fifty (50) or less. However, the Axis IV or V diagnosis rating shall be used as the basis for a denial only if those diagnoses are critical to establish the need for inpatient psychiatric facility treatment; and

3. The individual is currently experiencing problems related to the mental disorder diagnosed in B.l above in one (1) of the following categories designated as (a), (b), (c) and (d):

   a. Self-care Deficit (not Age Related): Basic impairment of needs for nutrition, sleep, hygiene, rest, or stimulation related to the individual's mental disorder.

      Indicators:
      (1) Self-care deficit severe and long-standing enough to prohibit participation in an alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications).
      (2) Self-care **deficit places child in life-threatening** physiological imbalance without skilled intervention

and supervision (examples: dehydration, starvation states, exhaustion due to extreme hyperactivity).
(3) Sleep deprivation or significant weight loss; or

b. Impaired Safety (Threat to Self or Others): Verbalization or gestures of intent to harm self or others caused by the individual's mental disorder.

Indicators:
(1) Threats accompanied by one (1) of the following:
(a) Depressed mood (irritable mood in children, weight gain, weight loss)
(b) Recent loss
(c) Recent suicide attempt or gesture or past history of multiple attempts or gestures
(d) Concomitant substance abuse
(e) Recent suicide or history of multiple suicides in family or peer group
(f) Aggression toward others
(2) Verbalization escalating in intensity; or verbalization of intent accompanied by gesture or plan; or

c. Impaired Thought Processes (Reality Testing): Inability to perceive and validate reality to the extent that the child cannot negotiate his basic environment, nor participate in family or school (paranoia, hallucinations, delusions).

Indicators:
(1) Disruption of safety of self, family, peer or community group.
(2) Impaired reality testing sufficient to prohibit participation in any community educational alternative.
(3) Not responsive to outpatient trial of medication or supportive care; or

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes which place the individual at risk.

Indicators:
(1) Family environment is causing escalation of individual's symptoms or places individual at risk.
(2) The family situation is not responsive to outpatient or community resources and intervention.
(3) Instability or disruption is escalating.
(4) The situation does not improve with the provision of economic or social resources.

(5) Severe behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse; and

4. The Qualified Mental Health Professional describes a proposed plan of treatment that requires the intensity of services available at an inpatient psychiatric level of care; specifically:

   a. Services shall be under the supervision of a psychiatrist.
   b. Intervention of qualified professionals shall be available twenty-four (24) hours a day.
   c. Multiple therapies (group counselling, individual counselling, recreational therapy, expressive therapies, etc.) shall be actively provided to the child.

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1. At admission, the treatment facility shall provide a description of the proposed plan for treatment illustrating the required intensity of services available at an inpatient psychiatric level of care. Within ten (10) days of admission, the facility shall provide a master treatment plan that includes the following:

   a. Problems related to the child's psychiatric condition.

   b. Measurable goals or objectives relevant to each of the problems.

   c. Interventions to assist the recipients in reaching goals or objectives, including individual, group, and where appropriate family therapy, and the staff who will provide the interventions.

   d. Time frames for reaching goals or objectives.

   e. In reviews of the master treatment plan, an evaluation of treatment progress to include measurement of progress toward goals or objectives, explanation of any failure to achieve goals or objectives and changes in the treatment plan. Each review shall confirm that inpatient psychiatric services are necessary to reach goals or objectives, and shall list the reasons for continuing stay.

2. The treatment facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, and time-framed discharge criteria.

3. Available clinical and research **data** supports the likelihood of positive outcome from inpatient psychiatric treatment **for** the patient's diagnosis and presenting symptoms.

D. Children and Adolescents placed in Psychiatric Residential Treatment Facilities shall meet additional requirements.

Individuals placed in PRTF care shall first meet the requirements in Sections A, B, and C above. The requirements of this section interpret sections A, B, and C as they apply to coverage of Psychiatric Residential Treatment Services:

1. The individual's behavior has disrupted his placement in a family or group residence two (2) or more times in the past year, or the individual has a persistent pattern of behavior that has severely disrupted life at home and school over the 9 months preceding inpatient care. For children under twelve (12) these time frames are six (6) months and six (6) months, respectively; and

2. The individual's mental disorder is rated "severe", or the presence of two (2) or more diagnoses on Axes I and II indicate that the individual's disturbance is severe or complex; and

3. Family functioning or social relatedness is seriously impaired as evidenced by one or more of the following circumstances:

   a. History of severe physical, sexual or emotional maltreatment;
   b. History of a disrupted adoption or multiple two (2) or more foster family placements;
   c. A physical assault against a parent or adult caregiver related to the individual's mental disorder;
   d. A history of sexual assault by the individual related to the individual's mental disorder;
   e. A history of fire setting resulting in damage to a residence related to the individual's mental disorder;

f. Runaways from two or more community placements by a child under age fourteen (14) related to the child's mental disorder; or

g. Other impairment of family functioning or social relatedness of similar severity; and

4. The child or adolescent does not fall into one of the following categories which are inappropriate for PRTF:

   a. Children and adolescents at risk of harm to self or others for whom no risk management plan appropriate for PRTF care can be developed. Examples of inappropriate risk may include:
      (1) History of many suicidal gestures and continuing suicidal thinking
      (2) Suicidal thinking associated with a medical condition which involves self-administered treatment, the denial of which could result in death or permanent harm.
   b. Children and adolescents who require substance abuse treatment before they can benefit from psychiatric residential treatment.
   c. Children and adolescents who are acutely psychotic or delirious (persons not oriented as a result of organic disorder).
   d. Children and adolescents with contraindicated medical conditions such as brittle diabetes and uncontrolled seizures.

5. Since only children and adolescents whose problems are severe, complex, and persistent will be admitted to PRTFs, the anticipated course of treatment for most recipients will be a gradual process with periods of progress and regression. Active treatment should continue toward the achievement of long-term goals, which may typically include the following:

   a. For problems in adult-child relationships, the child will demonstrate the ability to transfer relationships built with the facility's staff to parents or other caregivers in a less restrictive setting.

b. For problems of internalized self-control, the child will demonstrate less dependence on external controls in order that successful placement at a lower level of care may be predicted.

c. For problems related to the acquisition of critical life skills, the child (and family where appropriate) will demonstrate that skills in the areas of emotional management, relationships, and conflict resolution have been acquired and will be used to maintain healthy interpersonal relationships in a less restrictive setting.

d. For other problems, an observable and attainable goal or objective related to the child's long-term persistent problem(s).

e. Placement in a community school may be an appropriate intervention in support of goals and objectives in the treatment plan. Educational or vocational services may be provided outside the facility when inpatient services are extended to the off-site setting as part of the treatment plan or as a component of the child's discharge plan.

f. Therapeutic leave may be an appropriate component of the child's discharge plan.

APPENDIX I

UTILIZATION REVIEW FORMS

UTILIZATION REVIEW **FORMS**

I-1. Certification **For Psychiatric Facility Placement - Form L02**

I-2. Data Correction Form - Form L03

I-3. Inpatient Psychiatric Facility Placement Adverse Determination - Form L05

I-4. Acknowledgement of Request For Reconsideration - Form L06

I-5. Psychiatric Facility Placement Results of Reconsideration - Form L07

CERTIFICATION FOR PSYCHIATRIC FACILITY **PLACEMENT**
FORM LO2

Date: _____ **Telephone Notification Date:** _____ **Certification No.:** _____

Certification Period: From: _____ **Through:** _____ **Initial Certification** **Recertification**

Under authority of ___ **907 KAR 1:016** ___ **907 KAR 1:505 and based upon available clinical data, it has been determined that the patient listed below meets Kentucky Medicaid criteria for placement in a Psychiatric Hospital Psychiatric Residential Treatment Facility.**

Patient Information (Supplied by the Facility)

Name: **Reported Admission Date:** **MAID:**
Address: **SSN:**
Sex:
County: **Birthdate:**
Social History:
MAR STAT: _____ **LIV ARR:** _____ **TRANS FROM:** _____

1-Single	2-Married	1-Alone	2-W/Spouse	1-Home	Z-Acute Hosp.
3-Widowed	4-Divorced	3-W/Relative	4-W/Nonrelative	3-NF	4-Mental Hosp.
5-Separated	6-Unknown	5-Waiver Prog.	6-Foster Home	5-PC	6-Foster Home
		7-Institution	8-Unknown	7-ICF/MR/DD	8-IMD
				9-Other/Unkn.	IO-PRTF

Facility Name: **Physician:**
Provider No.: **License No.:**
Address: **Address:**

County: **Telephone:**
Caller: **Call Date:**

The hospital/facility attests that this admission is in compliance with all applicable federal and state regulations and procedures and that all required documentation has been incorporated into the patient's record to include a valid Certification of Need MAP-569 ___ MAP-570 Over.65. If subsequent information received by the review agency or Kentucky Medicaid establishes that this admission is not in compliance with applicable regulations and procedures because such compliance or patient information has been misrepresented by the patient, the patient's representative or the hospital/facility, this decision may be reversed or appropriately amended.

This certification is valid for the days listed above as the Certification Period. The patient will be responsible for payment for all inpatient psychiatric care provided on dates not covered by this Certification Form or another valid Medicaid Certification Form.

Reconsideration Rights/Procedures:
The patient has a right to a reconsideration if he disagrees with this determination. This request for reconsideration must be submitted in writing by the patient or his authorized representative within 30 days of the date of this notification. The written request must clearly indicate a desire for reconsideration and must be submitted to:

Mental Health Managment of America, Inc.
P.O. Box 70219
Nashville, TN 37207
Attention: Reconsideration Review
Kentucky Department of Medicaid

A description of the reconsideration process is attached.

RECONSIDERATION RIGHTS AND PROCEDURES

1. The Kentucky Department for Medicaid Services has contracted with a review agency, Mental Health Management of America, Inc. (MHMA), to perform reviews of all admissions of Kentucky Medicaid recipients to inpatient psychiatric facilities. In relation to such reviews, the decisions of MHMA are binding for Medicaid recipients. Review procedures are conducted under the provision of 907 KAR 1:016 for mental hospitals and 907 KAR 1:505 for psychiatric residential treatment facilities and the manual entitled Psychiatric Inpatient Facilities Utilization and Placement Review Manual which has been incorporated into these administrative regulations by reference.

2. The patient (Medicaid applicant or recipient) has a right to request a reconsideration if he/she or his/her authorized representative disagrees with a determination which is made by the review agency.

3. The request for reconsideration must be submitted in writing by the patient or his/her authorized representative within 30 days of the date of the written notification provided by the review agency.

4. The written reauest for reconsideration must clearly indicate a desire for a reconsideration and must be submitted to:

   Mental Health Management of America, Inc.
   P.O. Box 70219
   Nashville, TN 37207
   Attention: Reconsideration Review
   Kentucky Department of Medicaid

5. The review agency shall conduct the reconsideration within three (3) work days from their receipt of the written request.

6. The reconsideration shall consist of review of the medical records and/or additional relevant information submitted by the patient or his/her authorized representative for consideration. To be considered, copies of such evidence shall be submitted with the reconsideration request.

7. The reconsideration shall be conducted by a licensed physician who did not participate in the initial review. When requested in advance by the patient or his representative, the reconsideration shall be performed by a board eligible or board certified physician in the appropriate psychiatric specialty or subspecialty.

8. At the conclusion of the reconsideration, a determination shall be made and the review agency shall notify the patient or his authorized representative of the results within two (2) work days. Included with this notification shall be a description of the patient's further rights for appeal to the Medicaid Program along with the procedures for filing such appeals. Such subsequent appeals shall be made to the Medicaid Program and shall be presented at a formal hearing conducted by the Medicaid Program. However, the patient must complete the reconsideration process before subsequent appeals related to the review agency's determination may be made to Kentucky Medicaid Program.

9. All questions related to a specific review agency decision or the reconsideration process should be addressed to MHMA at (800) 388-6462.

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Physician
Facility
DMS
DSI

DATA CORRECTION FORM
FORM LO3

The following corrections must be made on data from the Initial Certification form for this Kentucky Medical Assistance Recipient.

Patient Name	**Date of Admission**
Facility Name	**Certification No.**
Facility No.	
Address	**Medicaid No.**

Corrections:

Reviewer's Signature	**Date**

Copies: DSI
Review Organization
Facility

INPATIENT PSYCHIATRIC FACILITY PLACEMENT
ADVERSE DETERMINATION
FORM LO5

Date:

Telephone Notification Date:

Patient Name:
MAID/SSN:
Address:

Facility Name:
Provider No.:
Address:

County:

Caller:
Physician:
Address:

Call Date:
License:

Reported Date of Admission:

Telephone:

Last Date of Medicaid Certification:

Reviewing Physician:

Under the authority and provisions of __ 907 KAR 1:016 __ 907 KAR 1:505 907 KAR 1:372, and based upon available clinical data, the request for Medicaid certification of the above individual for __ mental hospital __ psychiatric residential treatment facility placement is denied because the admission does not meet Medicaid medical necessity, program coverage or technical criteria as described in the Psychiatric Inpatient Facility Utilization and Placement Review Manual at the Sections cited below.

The patient is responsible for payment for all inpatient psychiatric facility services provided from _____ through _____.

This adverse determination was based upon the following specific factor(s) as indicated:

1. The admission is medically unnecessary because ambulatory care resources available in the community can meet the treatment needs of this individual (Section ____ Page ____). _____.

2. The admission is medically unnecessary because proper treatment of this indivdual's psychiatric condition does not require services on an inpatient basis under the direction of a physician (Section ____ Page). _____.

__3. The admission is medically unnecessary because inpatient treatment cannot reasonably be expected to improve this individual's condition or prevent further regression so that the services will be no longer needed (Section ____ Page _____). _____.

4. The admission is for a Medicaid non-covered service because the primary diagnosis and/or primary care needs of this individual are for chemical dependency services (Section ____ Page ____). _____.

5. Requested patient information and/or case documentation necessary to certify this admission was not provided by the facility or patient (Section ____ Page ____). _____.

__6. Medicaid technical criteria and/or documentation requirements were not fulfilled for this admission (Section ____ Page). _____.

__7. Other/Additional Comments. _____.

The patient has a right to a reconsideration if he disagrees with this determination. A description of the reconsideration process is attached.

RECONSIDERATION RIGHTS AND PROCEDURES

1. The Kentucky Department for Medicaid Services has contracted with a review agency, Mental Health Management of America, Inc. (MHMA), to perform reviews of all admissions of Kentucky Medicaid recipients to inpatient psychiatric facilities. In relation to such reviews, the decisions of MHMA are binding for Medicaid recipients. Review procedures are conducted under the provision of 907 KAR 1:016 for mental hospitals and 907 KAR 1:505 for psychiatric residential treatment facilities and the manual entitled Psychiatric Inpatient Facilities Utilization and Placement Review Manual which has been incorporated into these administrative regulations by reference.

2. The patient (Medicaid applicant or recipient) has a right to request a reconsideration if he/she or his/her authorized representative disagrees with a determination which is made by the review agency.

3. The request for reconsideration must be submitted in writing by the patient or his/her authorized representative within 30 days of the date of the written notification provided by the review agency.

4. The written request for reconsideration must clearly indicate a desire for a reconsideration and must be submitted to:

Mental Health Management of America, Inc.
P.O. Box 70219
Nashville, TN 37207
Attention: Reconsideration Review
Kentucky Department of Medicaid

5. The review agency shall conduct the reconsideration within three (3) work days from their receipt of the written request.

6. The reconsideration shall consist of review of the medical records and/or additional relevant information submitted by the patient or his/her authorized representative for consideration. To be considered, copies of such evidence shall be submitted with the reconsideration request.

7. The reconsideration shall be conducted by a licensed physician who did not participate in the initial review. When requested in advance by the patient or his representative, the reconsideration shall be performed by a board eligible or board certified physician in the appropriate psychiatric specialty or subspecialty.

8. At the conclusion of the reconsideration, a determination shall be made and the review agency shall notify the patient or his authorized representative of the results within two (2) work days. Included with this notification shall be a description of the patient's further rights for appeal to the Medicaid Program along with the procedures for filing such appeals. Such subsequent appeals shall be made to the Medicaid Program and shall be presented at a formal hearing conducted by the Medicaid Program. However, the patient must complete the reconsideration process before subsequent appeals related to the review agency's determination may be made to Kentucky Medicaid Program.

9. All questions related to a specific review agency decision or the reconsideration process should be addressed to MHMA at (800) 388-6462.

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ACKNOWLEDGEMENT OF REQUEST FOR RECONSIDERATION
FORM LO6

Patient Name: MAID No.:

Facility: **Date:**
Address:

A request for reconsideration has been filed by _____ **on behalf of the above-indicated individual for services provided at** _____. **The period at issue is** _____

This case will be reviewed on _____ **at** _____ **A.M., P.M., in the corporate office of Mental Health Management of America,** Inc., by a ___ **board eligible or certified child psychiatrist board eligible or certified child and adolescent psychiatrist board eligible or certified psychiatrist.**

The reconsideration shall consist of review of medical records and/or relevant information that was submitted with the reconsideration request.

Sincerely,

Mental Health Management of America, Inc.
P.O. Box 70219
Nashville, TN 37207
(615) 256-3400
(800) 388-6462

COPIES: **Patient/Legal Representative**
Physician
Facility
DSI
DMS

PSYCHIATRIC FACILITY PLACEMENT
RESULTS OF RECONSIDERATION
FORM LO7

Date:

Patient Name:
MAID/SSN:
Facility:

Reported Admission Date:
Physician:

In accordance with your request, a reconsideration of the previous review agency determination concerning your certification for services at the above facility was performed on _____ by the reconsideration officer listed below. Based upon available medical and case-related information, including such additional information as may have been submitted by the patient or his/her authorized representative, the reconsideration officer has determined that:

___ The previous review agency determination is reversed or amended and the patient is granted a period of certification for inpatient psychiatric service at the above facility FROM: _____ TO: _____ Certification, FORM LO2 will be sent confirming this action. The patient is responsible for payment for all inpatient psychiatric services which are provided on all dates not covered by the above certification period or another previously approved Medicaid certification period.

___ The previous review agency determination is upheld and the patient is responsible for the payment for all inpatient psychiatric services provided

The above reconsideration determination was made under the authority and provisions of ___ 907 KAR 1:016 ___ 907 KAR 1:505 and in accordance with the criteria and procedures listed in the manual entitled Psychiatric Inpatient Facilities Utilization and Placement Review Manual which has been incorporated into these Kentucky Administrative Regulations by reference. The specific basis for the determination is as follows:

If the patient or his/her authorized representative disagrees with this reconsideration determination, further appeal must be submitted to Kentucky Medicaid following the procedures listed on the attached page. Only the patient or his/her authorized representative may make such further appeal.

_____
Reconsideration Officer

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APPEAL TO MEDICAID

Further appeals will be conducted by the Cabinet for Human Resources. The' recipient possesses the right to a De novo hearing. As a Medicaid patient, only you or an authorized representative acting on your behalf may request a hearing if the determination is adverse in any respect.

In order to exercise this right, you or your authorized representative must file a written request clearly indicating a desire for a hearing within (20) days from the date of this notification. The request for a hearing may be filed directly to the Cabinet for Human Resources:

Director of Administrative Reviews
Department for Social Insurance
3rd Floor East
275 East Main Street
Frankfort, KY 40621

If you request a hearing you may represent yourself or be represented by an authorized representative, such as legal counsel, relative, friend or other spokeperson. You may contact the Department for Social Insurance located in your county of residence regarding the availability of free representation by legal aid services.

Your request for a hearing shall be acknowledged by the Cabinet for Human Resources, and shall contain information regarding the hearing process.